STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	12/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

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F0000	This visit was for the Investigation of Complaint IN00118712. Complaint IN00118712 - Substantiated, Federal/State deficiencies related to the allegations are cited at F223. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00117917 completed on 10/24/12. Survey dates: December 5, 6 & 7, 2012 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Survey team: Christi Davidson, RN-TC Janet Stanton, RN Michelle Hosteter, RN Census bed type: SNF: 3 SNF/NF: 52 Total: 55 Census payor type: Medicare: 9 Medicaid: 38 Other: 8	F0000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 55 Sample: 12 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/10/12 Cathy Emswiller RN			

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F0223 SS=B	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, record review and interview the facility failed to ensure a resident did not present with bruising to bilateral forearms while in the care of Certified Nursing Assistant [CNA] #1 documented in 1 of 2 facility incidents reviewed. (#I) Findings include: The record for Resident #I was reviewed on 12/5/12 at 1:55 p.m. Diagnoses included but were not limited to dementia, osteoarthritis, depression, and glaucoma. The most recent Minimum Data Set [MDS] Assessment for Resident #I dated 10/3/12 indicated a staff interview was required to assess the cognition of Resident #I. The cognitive assessment of Resident #I indicated the resident was moderately impaired and decisions were	F0223	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Due to the nature of the survey, no resident identifier was provided to the facility. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken? It is the intent of this facility to ensure all residents are free from bruising while in the care of Certified Nursing Assistants. All residents have the potential to be affected by the alleged defcient practice. Upon any resident's allegation of abusive behavior toward them or discovery of unknown bruising/injury, the facility will immediately begin an investigation. If a staff member has been identified, that staff member will immediately be suspended during the investigation process. A thorough assessment of the resident will be completed. The residents family/responsible party and	12/21/2012

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	poor. The MDS assessed the resident as a limited assist of one person physical assist to position the resident in the bed or move the resident side to side while in the bed. During the entrance conference on 12/5/12 at 9:50 a.m. with the Executive Director [E.D.] and the Director of Nursing [DoN] present, facility incidents that were reported to the Indiana State Department of Health in October and November 2012 were requested for review. A facility incident was provided by the E.D. and reviewed on 12/5/12 at 11:25 a.m. The report indicated the date of the incident was 11/29/12, and the time of the incident was 8:30 p.m. The report indicated, "...Resident Name: [name of Resident #I]...Brief Description of Incident: C.N.A. heard resident crying in room. C.N.A. entered room to find out what was wrong. Resident stated 'that big girl grabbed my arm and threw me in bed and hit me.' Charge nurse notified and assessed resident, at that time resident stated she was not hit but grabbed by arms and put into bed...Type of Injury/Injuries: Discoloration R [right] forearm 6.5 cm [centimeters] x 3.1 cm, discoloration L [left] forearm 6 cm x 5 cm...Immediate Action Taken:...Alleged C.N.A. immediately suspended. Administrator		physician will be notified. Appropriate care/first aide will be administered. Statements will be obtained from the resident, other residents on the unit/surrounding units, and staff members. The incident will be reported to the Indiana State Department of Health and local law enforcement agency as appropriate. Upon completion of the investigation, all information will be reviewed. In the event the alleged abuse incident is confirmed, appropriate disciplinary action will be taken. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All staff are in-serviced on Abuse during orientation upon hire, annually and as needed. The facility maintains an open door policy for all residents, family and staff to report any suspected abuse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? In-service records will be presented by the D.O.N. to the QA Committee during monthly QA Meetings to ensure staff education is occurring. Grievances will be presented by the Social Service Director to the QA Committee during monthly QA Meetins to ensure any allegation of abuse is investagated as appropriate.	

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	and D.O.N. notified immediately...MD [Medical Doctor] notified. Investigation initiated. Family notified...." In the investigation documentation, employee witness statements indicated Resident #I did not have bruising on arms or wrists on 11/28/12. A handwritten witness statement signed by the Activities Director dated 11/28/12 indicated, "At or around 7:45 while helping another CNA with putting a resident to bed...I heard crying coming from [Resident #I's] room...asked What was wrong. She stated 'that big girl grabbed my arm, threw me in the bed...I calmed her down...and called upper management [name of ADoN]...." A handwritten witness statement signed by LPN #2 dated 11/28/12 indicated, "...Went in to assess...and also get the story...{Resident #I] stated that 'That girl grabbed me by the arms and put me in the bed.'...'She grabbed me right here pointing to her forearms one at a time where there appeared to be visible bruises to both arms...[sign for left] Forearm measured 6 cm x 5 cm...[sign for right] forearm measured 6.5 cm x 3.1 cm...." A handwritten witness statement signed by CNA #1 dated 11/28/12 indicated, "...I			

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	didn't hit her she was angry about her clothes...." In the investigation documents a typed paragraph dated 11/28/12 indicated, "...Upon review of statements and interviews with [name of Resident #I] it was determined that bruising did occur...during HS [bedtime] care...statement was consistent during several conversations...We are unable to determine if the bruising during care...was willful and intentional on the part of the care giver or the result of hurried care on the part of the care giver. Regardless...the care giver assigned...and identified by [name of Resident #I] will be terminated." A Disciplinary Warning Notice dated 11/29/12 and signed by CNA #1 indicated CNA #1 was terminated for "Failure to follow company policy." A nurses note dated 11/28/12, untimed, entered by LPN #2 indicated during a skin assessment bruises were found on each forearm. The note indicated the bruise to the right forearm measured 6.5 cm x 3.1 cm, and the bruise to the left forearm measured 6 cm x 5 cm. The nurses note indicated the resident has had increased confusion and would be monitored. A social service note dated 11/29/12			

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	indicated, "SSD [Social Service Director] was told about previous incident the night before...Admin [Administrator] asked SSD to interview resident about incident dealing [sign for with] CNA on evening shif (sic) the night before...Will continue to observe...." A social service note dated 11/30/12 indicated, "SSD spoke [sign for with] res. [resident]...States she is fine and does feel safe here...." A social service note dated 12/3/12 indicated, "Writer met [sign for with] resident regarding to the follow-up after incident occuring (sic) [sign for with] CNA...is fine and feels safe...." During an observation on 12/6/12 at 10:22 a.m., Resident #I was sitting in a wheelchair outside of the resident's room. Resident #I did not answer questions, but kept pointing to her room. During an interview on 12/6/12 at 8:00 a.m., the E.D. indicated the police were notified of the allegation regarding Resident #I and CNA #1. The E.D. indicated the police officer attempted to interview Resident #I and filed a report. The E.D. indicated ISDH was notified and an investigation was conducted. The E.D. indicated CNA #1 was terminated.			

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	During an interview on 12/6/12 at 11:00 a.m., the ADoN [Assistant Director of Nursing] indicated she was notified of the incident by the Activities Director. She indicated CNA #1 was sent home immediately and an investigation was initiated upon notification. The ADoN indicated a full body check was performed on Resident #I. The ADoN indicated she was informed Resident #I had complained of "someone grabbed her arms." The ADoN indicated no previous complaints had been voiced about CNA #1. The ADoN indicated an abuse inservice was conducted on 12/4/12. The ADoN indicated Resident #I "is perfectly fine, now." The facility abuse policy was provided by the E.D. on 12/5/12 at 11:13 a.m. and indicated, "...Residents will be free from...physical and mental abuse...." This federal tag relates to complaint number IN00118712. 3.1-27(a)(1)			